

700381

February 5, 1973

TO: CHR File

FROM: M. S. Littman, M.D.

SUBJECT: 40-009

Copy of portion of chart of case 40-009

This ambulatory 75 year old white widow was admitted to  
from Hospital where she had been hospitalized for three days.  
She had been followed medically at since  
1945. She had an acute episode of abdominal pain and swelling for the  
last five days.

Present Illness

For many years the patient has had constipation and associated  
diverticulosis. She took metamucil. During Christmas holidays dietary  
indiscretions and consumption of many sweets occurred. She noticed  
gradual abdominal swelling that worsened five days previous to admission,  
and crampy, sharp pain over the entire abdomen developed. Her local  
physician, examined her at home and sent her to  
Hospital with the diagnosis of paralytic ileus secondary to peritonitis  
resulting from a perforated diverticulum. X-rays showed dilated loops of  
small bowel. Barium enema was negative except for multiple diverticula.  
Treatment consisted of nasogastric suction, ampicillin 500 mg. q. 6 h.  
After three days she was transferred to Strong Memorial Hospital.

Past History

She had been followed at Strong Memorial Hospital since 1945, admitted  
then for peripheral edema and skin rash of several weeks' duration. Laboratory  
studies showed hypoproteinemia, mild elevated bilirubin and thymol turbidity.  
Diagnosis was mild hepatitis and treatment consisted of diet and bed rest.  
There was complete recovery.

In 1946 she was admitted because of a skull fracture subsequent to  
falling. She had bloody spinal fluid and bleeding from the right ear.  
Residual complaints for months after discharge consisted of vertigo and  
frontal headaches.

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In 1953 a cystic lesion of the left third rib was resected. Pathological diagnosis was "neurofibroma".

In 1955 she had abdominal distress and gas after meals. —A large hiatus hernia was found.

In 1962 glucose tolerance test was diabetic, and in 1968 it was proved that abnormal glucose tolerance test was related to weight changes. Being overweight had always been a problem, weight 140-155 lbs. Her height was 5 ft. 1.5 inches.

In 1970 arthritis developed in hands, feet and sacroiliac joints and pain was controlled by eight Bufferin tablets per day.

In 1971 she had an iron deficiency anemia produced by a prolonged diet of milk and crackers. Serum iron was 28  $\mu$ g. %, iron binding capacity 480  $\mu$ g. %, and hematocrit was 27. Therapy consisted of iron, and hematocrit was increased to 44.

#### Family History

Widowed, one son, ~~relationship is strained~~, relationship is strained and cause not known. One sister with crippling rheumatoid arthritis, died in 1972. No history of arthritis in other family members.

#### Physical Examination

Blood pressure 140/88

She was not jaundiced. Abdomen was obese and distended. There was no tenderness on palpation, but there was rebound tenderness in all four quadrants. She had no edema.

#### Laboratory Data

Cl - 103 mEq./L., CO<sub>2</sub> 27 mEq./L., K 3.6 mEq./L.  
NA - 142 mEq./L., N - 6 mg. %

#### Hospital Course

Patient received I.V. fluids initially, then liquid diet. Ampicillin was continued for several days. Urinary output was satisfactory, though low. First bowel movement was on January 31, and weighed 222 gm.

cc: A. M. Brues, M.D.  
A. F. Stehney  
Medical Assistants

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